2024 PLANS AND PRODUCTS | CALIFORNIA

Complete Suite plan comparison chart

Use this overview of our Complete Suite portfolio to easily explore a wide range of Kaiser Permanente plans. This interactive tool also enables you to get quick side-by-side comparisons of the different plans we have to offer.

Compare. Select. Administer. It's that easy.

With Complete Suite, we've done the work for you. We've compiled our most popular standard midmarket plans in this interactive plan comparison chart, which allows you to easily compare plan benefits. And with a single request, you can get binding quotes in a matter of minutes for up to 1,000 members.

New for 2024! Complete Suite portfolio additions:

- **Fertility, optical, and hearing aids:** We've added fertility, optical, and hearing aid options to our Complete Suite portfolio. Go to **account.kp.org** to see the full list of ancillary options that can be paired with our Complete Suite medical plans – simply contact your Kaiser Permanente Account Representative for a quote.
- **New Virtual Complete plan:** A new Kaiser Permanente Virtual Complete™ plan with a lower deductible has been added to the portfolio. Plan 16019/16020 has a $1,500 deductible, a $30 copay for primary care (first 3 visits are not subject to deductible), and a $15 copay for generic drugs.
- **New coinsurance-based HMO:** A new HMO Low Coinsurance plan has been added to Complete Suite. Plan 16072/16073 has a $35 primary care copay and 20% plan coinsurance.

Other 2024 Complete Suite changes:

- To simplify our portfolio we eliminated the Deductible HMO with HRA plan name. Upon renewal, groups with Deductible HMO with HRA plans will be migrated to Deductible HMO plans with different ID numbers but **with identical benefits.** This change won't impact groups or members and doesn't affect Kaiser Permanente's HRA administration.
- 2023 plans with additional optical coverage have been removed from the 2024 Complete Suite portfolio but are still available for sale and renewal. Customers can now add standard optical coverage to any HMO, DHMO, or HSA-Qualified HDHP Complete Suite plan.
- HMO Low plan 9942/9943 has been removed from Complete Suite. Groups will be moved into 14622/14623, which is an identical plan except for a lower $3,000 out-of-pocket maximum.* Plan 9942/9943 is still available for sale and renewal outside of Complete Suite.
- HMO Low Coinsurance plan 13058/13059 has been removed from Complete Suite. Groups will be moved into plan 16033/16035 which is an identical plan except for a higher $40 brand drug copay.* Plan 13058/10359 is still available for sale and renewal outside of Complete Suite.
- HSA-Qualified PPO 13918/13919 has been removed from Complete Suite but is still available for sale and renewal.

*Impacted groups will be auto-renewed into 2024 replacement plans. Groups wishing to remain on their current plan may do so by notifying their Kaiser Permanente account representative.

How to compare plans

With our Complete Suite interactive plan comparison chart, you can choose up to 3 plans at a time and get as many comparisons as you'd like.

To get a comparison:

1. Click the **Overview** tab at the top of the page.
2. Check the box next to each plan you'd like to compare, then click the **Compare plans** button at the top-right corner of the page.
3. To remove a plan from your comparison, click the checked box to clear it. To remove all plans selected, click the **Reset** button at the bottom of the page.

You can also get more detailed information about each plan type by clicking the tabs at the top of the page —**HMO, DHMO** (deductible HMO), **HDHP** (high deductible health plan), or **Point-of-Service/PPO.** To go back to the plan comparison page at any time, simply click the **Overview** tab at the top-left corner of the page.

How to use this interactive PDF to compare plans:

1. Download the interactive PDF to your desktop.
2. Open the PDF with Adobe Reader.

The plan summary highlights the most frequently asked-about benefits and is for illustration purposes only. For a complete description, please refer to the appropriate *Evidence of Coverage* or *Certificate of Insurance* booklet, or contact your broker or Kaiser Permanente account manager.

Information may have changed since date of publication.

Ready to connect?

Check out our 2024 plans and request a quote from your Kaiser Permanente account representative today.

The HMO Tier of the Point-of-Service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the Participating and Non-Participating Provider Tiers of the POS plan and the PPO plan. KPIC is a subsidiary of Kaiser Foundation Health Plan, Inc.

2024 Complete Suite plans

Select the plans that you want to compare. You can choose up to 3 at a time.

Plans selected: ☐

HMO | DHMO | HDHP | POS/PPO

Compare plans

HMO plan families NCAL/SCAL plan ID – primary care office visit/hospital inpatient/out-of-pocket maximum		
HMO High[1,2]	HMO Mid[1,2]	HMO Low[1,2]
☐ **9961/9962** – $10/$0/$1,500	☐ **9983/9984** – $20/$250/$2,000	☐ **14602/14603** – $20/$250/$3,000
☐ **9965/9966** – $15/$0/$1,500	☐ **9989/9990** – $20/$500/$2,500	☐ **14606/14607** – $30/$250/$3,000
☐ **10003/10004** – $20/$0/$1,500	☐ **9930/9931** – $25/$500/$2,500	☐ **14610/14611** – $20/$500/$3,000
☐ **10011/10012** – $15/$250/$1,500	☐ **9987/9988** – $30/$250/$2,000	☐ **14614/14615** – $30/$500/$3,000
☐ **10015/10016** – $20/$250/$1,500	☐ **9991/9992** – $30/$500/$2,500	☐ **14618/14619** – $30/$500/$3,000
☐ **10048/10049** – $25/$250/$1,500		☐ **9979/9980** – $30/$500/$3,500
☐ **10052/10053** – $20/$500/$1,500		☐ **14622/14623** – $40/$500/$3,000
☐ **9970/9972** – $25/$500/$1,500		☐ **16072/16073**[3] – $35/20%/$4,000
☐ **9981/9982** – $30/$500/$1,500		☐ **16033/16035**[3] – $40/30%/$4,000 (formerly 13058/13059)

Reset

Clear all plans selected

1. HMO Low/Mid/High plans—HMO High, Mid, and Low designations are driven by the plans' out-of-pocket maximum levels. High plans offer the lowest out-of-pocket maximums. Low plans offer the highest out-of-pocket maximums. **2.** Traditional HMO—Pay a simple copay for most covered services. **3.** Coinsurance HMO—Pay office visit copays; coinsurance for most other services.

2024 Complete Suite plans

Click on the specific plan name to see your options for that plan.

Plans selected:

HMO | **DHMO** | HDHP | POS/PPO

Compare plans

Deductible HMO (DHMO) plan families NCAL/SCAL plan ID – deductible/primary care office visit/hospital inpatient	
Deductible HMO HO[1]	**Deductible HMO XD**[2]
☐ **8776/8777** – $250/$10/10%	☐ **8796/8797** – $250/$10/10%
☐ **8780/8781** – $500/$20/10%	☐ **8800/8801** – $500/$20/20%
☐ **8782/8783** – $750/$25/20%	☐ **8808/8809** – $750/$25/20%
☐ **8784/8785** – $1,000/$20/20%	☐ **8804/8805** – $1,000/$20/20%
☐ **8790/8791** – $1,500/$20/20%	☐ **8810/8811** – $1,000/$30/30%
☐ **14626/14627** – $2,000/$20/20%	☐ **8814/8815** – $1,500/$20/20%
☐ **14630/14631** – $2,500/$20/20%	☐ **8818/8819** – $2,000/$20/20%
☐ **14634/14635** – $1,500/$40/30%	☐ **14642/14643** – $1,500/$40/30%
☐ **14638/14639** – $3,000/$40/30%	☐ **14646/14647** – $2,500/$40/30%
	☐ **14650/14651** – $3,000/$40/30%
	☐ **14654/14655** – $3,500/$40/30%
	☐ **13868/13869** – $4,000/$40/30%
	☐ **14678/14679** – $5,000/$40/30%

Reset

Clear all plans selected

1. Deductible HMO HO – Most services are covered at a copay or coinsurance. A deductible applies to hospital services, such as inpatient hospital, outpatient surgery, and emergency room services. **2.** Deductible HMO XD – Provider office visits and pharmacy are covered at a copay or coinsurance. A deductible applies to most other services.

2024 Complete Suite plans

Click on the specific plan name to see your options for that plan.

Plans selected:

Compare plans

Deductible HMO (DHMO) plan families NCAL/SCAL plan ID – deductible/primary care office visit/hospital inpatient	
DHMO XP[1]	**Virtual Complete**
☐ **16028/16029** – $1,000/$20/20% (formerly 8759/8760)	☐ **16019/16020** – $1,500/$30/20%
☐ **16030/16031** – $1,500/$20/20% (formerly 8761/8762)	☐ **13770/13771** – $2,000/$30/20%
☐ **16032/16034** – $2,000/$20/20% (formerly 8763/8764)	☐ **13774/13775** – $2,500/$40/20%
☐ **16038/16039** – $2,500/$20/20% (formerly 8765/8766)	☐ **13778/13779** – $3,000/$40/30%
☐ **16026/16027** – $3,000/30%/30% (formerly 7823/7824)	☐ **13782/13783** – $4,000/$50/30%
☐ **16048/16049** – $3,500/30%/30% (formerly 13050/13051)	☐ **13786/13787** – $5,000/$50/40%
☐ **16054/16055** – $4,000/30%/30% (formerly 13822/13823)	☐ **14682/14683** – $6,000/$50/40%
	Deductible HMO CDO[2]
	☐ **13860/13861** – $5,000/$50/30%
	☐ **13858/13859** – $5,500/$50/40%

Reset

Clear all plans selected

1. Deductible HMO XP – Pharmacy is covered at a copay or coinsurance. A deductible applies to most other services. **2.** Deductible HMO CDO – Preventive care is covered at no cost. A deductible applies to most services, including pharmacy.

2024 Complete Suite plans

Click on the specific plan name to see your options for that plan.

Plans selected:

HMO | DHMO | **HDHP** | POS/PPO

Compare plans

High Deductible Health Plan (HDHP) NCAL/SCAL plan ID – deductible/primary care office visit/hospital inpatient
HSA-qualified HDHP HMO[1]
☐ **16279/16280** – $1,600/$20/$250
☐ **16281/16282** – $1,600/10%/10%
☐ **16278/16277** – $3,200/$0/$0
☐ **16265/16266** – $2,000/$30/$250
☐ **16269/16270** – $2,500/$30/$250
☐ **16273/16274** – $3,200/$30/30%
☐ **14670/14671** – $3,500/$30/30%
☐ **14674/14675** – $4,500/$40/40%
☐ **13854/13855** – $4,500/40%/40%
☐ **13850/13851** – $5,500/$50/40%

Reset

Clear all plans selected

1. HSA-qualified HDHP HMO – All services, except preventive services, are subject to a deductible.

2024 Complete Suite plans

Click on the specific plan name to see your options for that plan.

Plans selected:

Compare plans

POS/PPO plans NCAL/SCALplanID – deductible by tier/office visit by tier	
POS plans	PPO plans
☐ **13886/13887** – $0/$500/$1,000; $20/$35/40%	☐ **13898/13899** – $500/$1,500; $20/40%
☐ **13890/13891** – $0/$1,000/$2,000; $25/$50/40%	☐ **13902/13903** – $750/$1,750; $30/40%
☐ **13894/13895** – $0/$1,500/$3,000; $30/20%/50%	☐ **13906/13907** – $1,000/$2,000; $35/40%
	☐ **13910/13911** – $1,500/$3,000; $35/40%
	☐ **13914/13915** – $2,000/$4,000; $40/50%

Reset

Clear all plans selected

The HMO Tier of the Point-of-Service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the Participating and Non-Participating Provider Tiers of the POS plan and the PPO plan. KPIC is a subsidiary of Kaiser Foundation Health Plan, Inc.

Compare plans Plans selected:

Complete Suite category	HMO			
	☐ HMO High[1]	☐ HMO High[1]	☐ HMO High[1]	☐ HMO High[1]
NCAL/SCAL plan ID	9961/9962	9965/9966	10003/10004	10011/10012
Plan deductible (individual/family)	None	None	None	None
Out-of-pocket maximum (individual/family)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$10	$15	$20	$15
Hospital inpatient (per admission)	No charge	No charge	No charge	$250
Outpatient surgery (per procedure)	$10	$15	$20	$15
Emergency care	$100	$100	$100	$100
Prescription drugs				
Generic	$10	$10	$10	$10
Brand	$20	$20	$20	$30
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$50	$50	$50	$50
CT/PET/MRI (per procedure)	No charge	No charge	No charge	No charge
Lab/X-ray (per encounter)	No charge	No charge	No charge	No charge
Durable medical equipment	20%	20%	20%	20%
Fertility services	Same as medical benefit	Same as medical benefit	Same as medical benefit	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Traditional HMO—Pay a simple copay for most covered services. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HMO			
	☐ HMO High[1]	☐ HMO High[1]	☐ HMO High[1]	☐ HMO High[1]
NCAL/SCAL plan ID	10015/10016	10048/10049	10052/10053	9970/9972
Plan deductible (individual/family)	None	None	None	None
Out-of-pocket maximum (individual/family)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$20	$25	$20	$25
Hospital inpatient (per admission)	$250	$250	$500	$500
Outpatient surgery (per procedure)	$20	$25	$100	$100
Emergency care	$100	$100	$100	$100
Prescription drugs				
Generic	$10	$10	$15	$15
Brand	$30	$30	$35	$35
Specialty	20%, not to exceed $250	20%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	$50	$50	$100	$100
CT/PET/MRI (per procedure)	No charge	No charge	$50	$50
Lab/X-ray (per encounter)	No charge	No charge	$10	$10
Durable medical equipment	20%	20%	20%	20%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Traditional HMO—Pay a simple copay for most covered services. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HMO		
	☐ HMO High[1]	☐ HMO Mid[1]	☐ HMO Mid[1]
NCAL/SCAL plan ID	9981/9982	9983/9984	9989/9990
Plan deductible (individual/family)	None	None	None
Out-of-pocket maximum (individual/family)	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$30	$20	$20
Hospital inpatient (per admission)	$500	$250	$500
Outpatient surgery (per procedure)	$100	$100	$250
Emergency care	$100	$100	$100
Prescription drugs			
Generic	$15	$15	$15
Brand	$35	$30	$35
Specialty	30%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	$100	$100	$100
CT/PET/MRI (per procedure)	$50	$50	$50
Lab/X-ray (per encounter)	$10	$10	$10
Durable medical equipment	20%	20%	20%
Fertility services	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge

1. Traditional HMO—Pay a simple copay for most covered services. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HMO			
	☐ HMO Mid[1]	☐ HMO Mid[1]	☐ HMO Mid[1]	☐ HMO Low[1]
NCAL/SCAL plan ID	9930/9931	9987/9988	9991/9992	14602/14603
Plan deductible (individual/family)	None	None	None	None
Out-of-pocket maximum (individual/family)	$2,500/$5,000	$2,000/$4,000	$2,500/$5,000	$3,000/$6,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$25	$30	$30	$20/$40
Hospital inpatient (per admission)	$500	$250	$500	$250 per day, first 3 days
Outpatient surgery (per procedure)	$250	$100	$250	$125
Emergency care	$100	$100	$100	$100
Prescription drugs				
Generic	$15	$15	$15	$10
Brand	$35	$30	$35	$30
Specialty	30%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$100	$100	$100	$100
CT/PET/MRI (per procedure)	$50	$50	$50	$100
Lab/X-ray (per encounter)	$10	$10	$10	$10
Durable medical equipment	20%	20%	20%	50%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Traditional HMO—Pay a simple copay for most covered services. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HMO				
	☐ HMO Low[1]	☐ HMO Low[1]	☐ HMO Low[1]	☐ HMO Low[1]	☐ HMO Low[1]
NCAL/SCAL plan ID	14606/14607	14610/14611	14614/14615	14618/14619	9979/9980
Plan deductible (individual/family)	None	None	None	None	None
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000	$3,500/$7,000
Telehealth[2]	No charge	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge	No charge
Primary and specialty care visit	$30/$40	$20/$40	$30/$40	$30/$40	$30/$50
Hospital inpatient (per admission)	$250 per day, first 3 days	$500 per day, first 3 days	$500 per day, first 3 days	$500 per day	$500 per day
Outpatient surgery (per procedure)	$125	$250	$250	$250	$250
Emergency care	$100	$150	$150	$150	$150
Prescription drugs					
Generic	$10	$15	$15	$15	$15
Brand	$30	$35	$35	$35	$35
Specialty	20%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	$100	$150	$150	$150	$150
CT/PET/MRI (per procedure)	$100	$100	$100	$100	$100
Lab/X-ray (per encounter)	$10	$10	$10	$10	$10
Durable medical equipment	50%	50%	50%	50%	50%
Fertility services	50%	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge	No charge

1. Traditional HMO—Pay a simple copay for most covered services. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HMO		
	☐ HMO Low[1]	☐ HMO Low (Coinsurance)[2]	☐ HMO Low (Coinsurance)[2]
NCAL/SCAL plan ID	14622/14623	16072/16073	16033/16035
Plan deductible (individual/family)	None	None	None
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$4,000/$8,000	$4,000/$8,000
Telehealth[3]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$40/$50	$35/$50	$40/$50
Hospital inpatient (per admission)	$500 per day	20%	30%
Outpatient surgery (per procedure)	$250	20%	30%
Emergency care	$150	20%	30%
Prescription drugs			
Generic	$15	$15	$15
Brand	$35	$40	$40
Specialty	30%, not to exceed $250	20%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	$150	$150	$150
CT/PET/MRI (per procedure)	$100	20%, not to exceed $150	30%, not to exceed $150
Lab/X-ray (per encounter)	$10	$15	$15
Durable medical equipment	50%	50%	50%
Fertility services	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge

1. Traditional HMO—Pay a simple copay for most covered services. **2.** Coinsurance HMO—Pay office visit copays; coinsurance for most other services. **3.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO		
	☐ Deductible HMO HO[1]	☐ Deductible HMO HO[1]	☐ Deductible HMO HO[1]
NCAL/SCAL plan ID	8776/8777	8780/8781	8782/8783
Plan deductible (individual/family)	$250/$500	$500/$1,000	$750/$1,500
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$10	$20	$25
Hospital inpatient (per admission)	10% after deductible	10% after deductible	20% after deductible
Outpatient surgery (per procedure)	10% after deductible	10% after deductible	20% after deductible
Emergency care	10% after deductible	10% after deductible	20% after deductible
Prescription drugs			
Generic	$10	$10	$10
Brand	$30	$30	$30
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$150	$150	$150
CT/PET/MRI (per procedure)	10%, not to exceed $150	10%, not to exceed $150	20%, not to exceed $150
Lab/X-ray (per encounter)	$10	$10	$10
Durable medicalequipment	20%	20%	20%
Fertility services	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge

1. Deductible HMO HO—Most services are covered at a copay or coinsurance. A deductible applies to hospital services, such as inpatient hospital, outpatient surgery, and emergency room services. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO		
	☐ Deductible HMO HO[1]	☐ Deductible HMO HO[1]	☐ Deductible HMO HO[1]
NCAL/SCAL plan ID	8784/8785	8790/8791	14626/14627
Plan deductible (individual/family)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$4,000/$8,000	$4,500/$9,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$20	$20	$20/$40
Hospital inpatient (per admission)	20% after deductible	20% after deductible	20% after deductible
Outpatient surgery (per procedure)	20% after deductible	20% after deductible	20% after deductible
Emergency care	20% after deductible	20% after deductible	20% after deductible
Prescription drugs			
Generic	$10	$10	$10
Brand	$30	$30	$30
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$150	$150	$150
CT/PET/MRI (per procedure)	20%, not to exceed $150	20%, not to exceed $150	20%, not to exceed $150
Lab/X-ray (per encounter)	$10	$10	$10
Durable medical equipment	20%	20%	20%
Fertility services	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge

1. Deductible HMO HO—Most services are covered at a copay or coinsurance. A deductible applies to hospital services, such as inpatient hospital, outpatient surgery, and emergency room services. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO		
	☐ Deductible HMO HO[1]	☐ Deductible HMO HO[1]	☐ Deductible HMO HO[1]
NCAL/SCAL plan ID	14630/14631	14634/14635	14638/14639
Plan deductible (individual/family)	$2,500/$5,000	$1,500/$3,000	$3,000/$6,000
Out-of-pocket maximum (individual/family)	$5,000/$10,000	$4,000/$8,000	$6,000/$12,000
Telehealth[2]	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$20/$40	$40/$50	$40/$50
Hospital inpatient (per admission)	20% after deductible	30% after deductible	30% after deductible
Outpatient surgery (per procedure)	20% after deductible	30% after deductible	30% after deductible
Emergency care	20% after deductible	30% after deductible	30% after deductible
Prescription drugs			
Generic	$10	$10	$10
Brand	$30	$30	$30
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$150	$150	$150
CT/PET/MRI (per procedure)	20%, not to exceed $150	30%, not to exceed $150	30%, not to exceed $150
Lab/X-ray (per encounter)	$10	$15	$15
Durable medical equipment	20%	20%	20%
Fertility services	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge

1. Deductible HMO HO—Most services are covered at a copay or coinsurance. A deductible applies to hospital services, such as inpatient hospital, outpatient surgery, and emergency room services. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO			
	☐ Deductible HMO XD[1]	☐ Deductible HMO XD[1]	☐ Deductible HMO XD[1]	☐ Deductible HMO XD[1]
NCAL/SCAL plan ID	8796/8797	8800/8801	8808/8809	8804/8805
Plan deductible (individual/family)	$250/$500	$500/$1,000	$750/$1,500	$1,000/$2,000
Out-of-pocket maximum (individual/family)	$2,500/$5,000	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$10	$20	$25	$20
Hospital inpatient (per admission)	10% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient surgery (per procedure)	10% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency care	10% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription drugs				
Generic	$10	$10	$10	$10
Brand	$30	$30	$30	$30
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$150 after deductible	$150 after deductible	$150 after deductible	$150 after deductible
CT/PET/MRI (per procedure)	10% not to exceed $150, after deductible	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible
Lab/X-ray (per encounter)	$10 after deductible	$10 after deductible	$10 after deductible	$10 after deductible
Durable medical equipment	20%	20%	20%	20%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO XD—Provider office visits and pharmacy are covered at a copay or coinsurance. A deductible applies to most other services.
2. Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO			
	☐ Deductible HMO XD[1]	☐ Deductible HMO XD[1]	☐ Deductible HMO XD[1]	☐ Deductible HMO XD[1]
NCAL/SCAL plan ID	8810/8811	8814/8815	8818/8819	14642/14643
Plan deductible (individual/family)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$1,500/$3,000
Out-of-pocket maximum (individual/family)	$3,000/$6,000	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$30	$20	$20	$40/$50
Hospital inpatient (per admission)	30% after deductible	20% after deductible	20% after deductible	30% after deductible
Outpatient surgery (per procedure)	30% after deductible	20% after deductible	20% after deductible	30% after deductible
Emergency care	30% after deductible	20% after deductible	20% after deductible	30% after deductible
Prescription drugs				
Generic	$10	$10	$10	$10
Brand	$30	$30	$30	$30
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$150 after deductible	$150 after deductible	$150 after deductible	$150 after deductible
CT/PET/MRI (per procedure)	30% not to exceed $150, after deductible	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible	30% not to exceed $150, after deductible
Lab/X-ray (per encounter)	$10 after deductible	$10 after deductible	$10 after deductible	$15 after deductible
Durable medical equipment	20%	20%	20%	20%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO XD—Provider office visits and pharmacy are covered at a copay or coinsurance. A deductible applies to most other services.
2. Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO			
	☐ Deductible HMO XD[1]	☐ Deductible HMO XD[1]	☐ Deductible HMO XD[1]	☐ Deductible HMO XD[1]
NCAL/SCAL plan ID	14646/14647	14650/14651	14654/14655	13868/13869
Plan deductible (individual/family)	$2,500/$5,000	$3,000/$6,000	$3,500/$7,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$5,000/$10,000	$6,000/$12,000	$6,500/$13,000	$7,000/$14,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$40/$50	$40/$50	$40/$50	$40/$50
Hospital inpatient (per admission)	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient surgery (per procedure)	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Emergency care	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Prescription drugs				
Generic	$10	$10	$10	$15
Brand	$30	$30	$30	$40
Specialty	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	$150 after deductible	$150 after deductible	$150 after deductible	$150 after deductible
CT/PET/MRI (per procedure)	30% not to exceed $150, after deductible	30% not to exceed $150, after deductible	30% not to exceed $150, after deductible	30% not to exceed $150, after deductible
Lab/X-ray (per encounter)	$15 after deductible	$15 after deductible	$15 after deductible	$15 after deductible
Durable medical equipment	20%	20%	20%	30%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO XD—Provider office visits and pharmacy are covered at a copay or coinsurance. A deductible applies to most other services.
2. Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO			
	☐ Deductible HMO XD[1]	☐ Deductible HMO XP[2]	☐ Deductible HMO XP[2]	☐ Deductible HMO XP[2]
NCAL/SCAL plan ID	14678/14679	16028/16029	16030/16031	16032/16034
Plan deductible (individual/family)	$5,000/$10,000	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000
Out-of-pocket maximum (individual/family)	$8,000/$16,000	$2,000/$4,000	$3,000/$6,000	$4,000/$8,000
Telehealth[3]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$40/$50	$20 after deductible	$20 after deductible	$20 after deductible
Hospital inpatient (per admission)	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient surgery (per procedure)	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency care	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription drugs				
Generic	$15	$10	$10	$10
Brand	$40	$30	$30	$30
Specialty	30%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250	20%, not to exceed $250
Emergency ambulance services (per trip)	$150 after deductible	$150 after deductible	$150 after deductible	$150 after deductible
CT/PET/MRI (per procedure)	30% not to exceed $150, after deductible	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible	20% not to exceed $150, after deductible
Lab/X-ray (per encounter)	$15 after deductible	$10 after deductible	$10 after deductible	$10 after deductible
Durable medical equipment	30%	20%	20%	20%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO XD—Provider office visits and pharmacy are covered at a copay or coinsurance. A deductible applies to most other services. **2.** Deductible HMO XP—Pharmacy is covered at a copay or coinsurance. A deductible applies to most other services. **3.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO			
	☐ Deductible HMO XP[1]	☐ Deductible HMO XP[1]	☐ Deductible HMO XP[1]	☐ Deductible HMO XP[1]
NCAL/SCAL plan ID	16038/16039	16026/16027	16048/16049	16054/16055
Plan deductible (individual/family)	$2,500/$5,000	$3,000/$6,000	$3,500/$7,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$5,000/$10,000	$6,000/$12,000	$6,500/$13,000	$7,000/$14,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$20 after deductible	30% after deductible	30% after deductible	30% after deductible
Hospital inpatient (per admission)	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient surgery (per procedure)	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Emergency care	20% after deductible	30% after deductible	30% after deductible	30% after deductible
Prescription drugs				
Generic	$10	30%, not to exceed $50	30%, not to exceed $50	30%, not to exceed $50
Brand	$30	30%, not to exceed $100	30%, not to exceed $100	30%, not to exceed $100
Specialty	20%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250	30%, not to exceed $250
Emergency ambulance services (per trip)	$150 after deductible	30% after deductible	30% after deductible	30% after deductible
CT/PET/MRI (per procedure)	20% not to exceed $150, after deductible	30% after deductible	30% after deductible	30% after deductible
Lab/X-ray (per encounter)	$10 after deductible	30% after deductible	30% after deductible	30% after deductible
Durable medical equipment	20%	30%	30%	30%
Fertility services	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO XP–Pharmacy is covered at a copay or coinsurance. A deductible applies to most other services. **2.** Telehealth–Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	DHMO				
	☐ Virtual Complete	☐ Virtual Complete	☐ Virtual Complete	☐ Virtual Complete	☐ Virtual Complete
NCAL/SCAL plan ID	16019/16020	13770/13771	13774/13775	13778/13779	13782/13783
Plan deductible (individual/family)	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000	$3,000/$6,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$4,500/$9,000	$5,000/$10,000	$5,500/$11,000	$6,000/$12,000	$7,000/$14,000
Telehealth[1]	No charge	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge	No charge
Primary and specialty care visit	$30 after deductible[2]	$30 after deductible[2]	$40 after deductible[2]	$40 after deductible[2]	$50 after deductible[2]
Hospital inpatient (per admission)	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Outpatient surgery (per procedure)	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Emergency care	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Prescription drugs					
Generic	$15	$15	$15	$15	$15
Brand	$30 after deductible	$30 after deductible	$40 after deductible	$40 after deductible	$50 after deductible
Specialty	20% after deductible, not to exceed $250	20% after deductible, not to exceed $250	20% after deductible, not to exceed $250	30% after deductible, not to exceed $250	30% after deductible, not to exceed $250
Emergency ambulance services (per trip)	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
CT/PET/MRI (per procedure)	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Lab/X-ray (per encounter)	Lab: $15 no deductible X-ray: 20% after deductible	Lab: $15 no deductible X-ray: 20% after deductible	Lab: $15 no deductible X-ray: 20% after deductible	Lab: $15 no deductible X-ray: 30% after deductible	Lab: $15 no deductible X-ray: 30% after deductible
Durable medical equipment	20%	20%	20%	30%	30%
Fertility services	50%	50%	50%	50%	50%
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge	No charge

1. Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers. **2.** Plan deductible doesn't apply to the first 3 visits combined for primary care, urgent care, mental health, and substance use disorder treatment.

Compare plans Plans selected:

Complete Suite category	DHMO			
	☐ Virtual Complete	☐ Virtual Complete	☐ Deductible HMO CDO[1]	☐ Deductible HMO CDO[1]
NCAL/SCAL plan ID	13786/13787	14682/14683	13860/13861	13858/13859
Plan deductible (individual/family)	$5,000/$10,000	$6,000/$12,000	$5,000/$10,000	$5,500/$11,000
Out-of-pocket maximum (individual/family)	$8,000/$16,000	$8,000/$16,000	$7,000/$14,000	$7,500/$15,000
Telehealth[2]	No charge	No charge	No charge	No charge
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$50 after deductible[3]	$50 after deductible[3]	$50 after deductible[3]	$50 after deductible[3]
Hospital inpatient (per admission)	40% after deductible	40% after deductible	30% after deductible	40% after deductible
Outpatient surgery (per procedure)	40% after deductible	40% after deductible	30% after deductible	40% after deductible
Emergency care	40% after deductible	40% after deductible	30% after deductible	40% after deductible
Prescription drugs				
Generic	$15	$15	$15 after deductible[4]	$15 after deductible[4]
Brand	$50 after deductible	$50 after deductible	$50 after deductible	40% not to exceed $100, after deductible
Specialty	40% not to exceed $250, after deductible	40% not to exceed $250, after deductible	30% not to exceed $250, after deductible	40% not to exceed $250, after deductible
Emergency ambulance services (per trip)	40% after deductible	40% after deductible	30% after deductible	40% after deductible
CT/PET/MRI (per procedure)	40% after deductible	40% after deductible	30% after deductible	40% after deductible
Lab/X-ray (per encounter)	Lab: $15 no deductible X-ray: 40% after deductible	Lab: $15 no deductible X-ray: 40% after deductible	30% after deductible	40% after deductible
Durable medical equipment	40%	40%	30%	40%
Fertility services	50%	50%	Not covered	Not covered
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	No charge	No charge	No charge

1. Deductible HMO CDO—Preventive care is covered at no cost. A deductible applies to most services, including pharmacy. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers. **3.** Plan deductible doesn't apply to the first 3 visits combined for primary care, urgent care, mental health, and substance use disorder treatment. **4.** Supplemental preventive drugs available at a lower cost share and before plan deductible. All other prescriptions are subject to plan deductible.

Compare plans Plans selected:

Complete Suite category	HDHP		
	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]
NCAL/SCAL plan ID	16279/16280	16281/16282	16278/16277
Plan deductible			
Self-only	$1,600	$1,600	$3,200
Family member/family	$3,200/$3,200	$3,200/$3,200	$3,200/$6,400
Out-of-pocket maximum			
Self-only	$3,200	$3,200	$3,200
Family member/family	$3,200/$6,400	$3,200/$6,400	$3,200/$6,400
Telehealth[2]	$0 after deductible	$0 after deductible	$0 after deductible
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$20 after deductible	10% after deductible	$0 after deductible
Hospital inpatient (per admission)	$250 after deductible	10% after deductible	$0 after deductible
Outpatient surgery (per procedure)	$150 after deductible	10% after deductible	$0 after deductible
Emergency care	$100 after deductible	10% after deductible	$0 after deductible
Prescription drugs			
Generic	$10 after deductible	$10 after deductible	$0 after deductible
Brand	$30 after deductible	$30 after deductible	$0 after deductible
Specialty	20% not to exceed $250, after deductible	20% not to exceed $250, after deductible	$0 after deductible
Emergency ambulance services (per trip)	$100 after deductible	10% after deductible	$0 after deductible
CT/PET/MRI (per procedure)	$150 after deductible	10% after deductible	$0 after deductible
Lab/X-ray (per encounter)	$10 after deductible	10% after deductible	$0 after deductible
Durable medical equipment	20% after deductible	10% after deductible	$0 after deductible
Fertility services	Not covered	Not covered	Not covered
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge after deductible	No charge after deductible	No charge after deductible

1. HSA-qualified HDHP HMO—All services, except preventive services, are subject to a deductible. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HDHP		
	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]
NCAL/SCAL plan ID	16265/16266	16269/16270	16273/16274
Plan deductible			
Self-only	$2,000	$2,500	$3,200
Family member/family	$3,200/$4,000	$3,200/$5,000	$3,200/$6,400
Out-of-pocket maximum			
Self-only	$3,500	$4,500	$5,250
Family member/family	$3,500/$7,000	$4,500/$9,000	$5,250/$10,500
Telehealth[2]	$0 after deductible	$0 after deductible	$0 after deductible
Preventive care	No charge	No charge	No charge
Primary and specialty care visit	$30/$50 after deductible	$30/$50 after deductible	$30/$50 after deductible
Hospital inpatient (per admission)	$250 after deductible	$250 after deductible	30% after deductible
Outpatient surgery (per procedure)	$150 after deductible	$150 after deductible	30% after deductible
Emergency care	$100 after deductible	$100 after deductible	30% after deductible
Prescription drugs			
Generic	$10 after deductible	$10 after deductible	$15 after deductible
Brand	$30 after deductible	$30 after deductible	$30 after deductible
Specialty	20% not to exceed $250, after deductible	20% not to exceed $250, after deductible	20% not to exceed $250, after deductible
Emergency ambulance services (per trip)	$100 after deductible	$100 after deductible	$100 after deductible
CT/PET/MRI (per procedure)	$150 after deductible	$150 after deductible	30% not to exceed $150, after deductible
Lab/X-ray (per encounter)	$10 after deductible	$10 after deductible	$10 after deductible
Durable medical equipment	20% after deductible	20% after deductible	20% after deductible
Fertility services	Not covered	Not covered	Not covered
Prenatal care and well-baby visits	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge after deductible	No charge after deductible	No charge after deductible

1. HSA-qualified HDHP HMO—All services, except preventive services, are subject to a deductible. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers.

Compare plans Plans selected:

Complete Suite category	HDHP			
	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]	☐ HSA-qualified HDHP HMO[1]
NCAL/SCAL plan ID	14670/14671	14674/14675	13854/13855	13850/13851
Plan deductible				
Self-only	$3,500	$4,500	$4,500	$5,500
Family member/family	$3,500/$7,000	$4,500/$9,000	$4,500/$9,000	$5,500/$11,000
Out-of-pocket maximum				
Self-only	$6,000	$6,250	$6,500	$7,000
Family member/family	$6,000/$12,000	$6,250/$12,500	$6,500/$13,000	$7,000/$14,000
Telehealth[2]	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible
Preventive care	No charge	No charge	No charge	No charge
Primary and specialty care visit	$30/$50 after deductible	$40/$50 after deductible	40% after deductible	$50 after deductible
Hospital inpatient (per admission)	30% after deductible	40% after deductible	40% after deductible	40% after deductible
Outpatient surgery (per procedure)	30% after deductible	40% after deductible	40% after deductible	40% after deductible
Emergency care	30% after deductible	$250 after deductible	40% after deductible	40% after deductible
Prescription drugs				
Generic	$15 after deductible	$15 after deductible	30% not to exceed $50, after deductible	$15 after deductible[3]
Brand	$35 after deductible	$35 after deductible	40% not to exceed $100, after deductible	40% not to exceed $100, after deductible
Specialty	30% not to exceed $250, after deductible	30% not to exceed $250, after deductible	40% not to exceed $250, after deductible	40% not to exceed $250, after deductible
Emergency ambulance services (per trip)	30% after deductible	40% after deductible	40% after deductible	40% after deductible
CT/PET/MRI (per procedure)	30% after deductible	40% not to exceed $150, after deductible	40% after deductible	40% after deductible
Lab/X-ray (per encounter)	$10 after deductible	40% after deductible	40% after deductible	40% after deductible
Durable medical equipment	30% after deductible	40% after deductible	40% after deductible	40% after deductible
Fertility services	Not covered	Not covered	Not covered	Not covered
Prenatal care and well-baby visits	No charge	No charge	No charge	No charge
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible

1. HSA-qualified HDHP HMO—All services, except preventive services, are subject to a deductible. **2.** Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available. These features are available when you get care from Kaiser Permanente providers. **3.** Supplemental preventive drugs available at a lower cost share and before plan deductible.

Compare plans Plans selected:

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 13886/13887		
Tier	HMO Tier	Participating Provider Tier	Nonparticipating Provider Tier
Plan deductible (individual/family)	$0/$0	$500/$1,000	$1,000/$2,000
Out-of-pocket maximum (individual/family)	$1,500/$3,000	$3,000/$6,000	$6,000/$12,000
Telehealth[2]	No charge	$35	40% after deductible
Preventive care	No charge	No charge	40%
Primary and specialty care visit	$20	$35	40% after deductible
Hospital inpatient (per admission)	$250	$250 + 20% after deductible	$500 + 40% after deductible
Outpatient surgery (per procedure)	$100	20% after deductible	40% after deductible
Emergency care	$150	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$10	$20 preferred, $50 nonpreferred	Not covered
Brand	$30	$40 preferred, $50 nonpreferred	Not covered
Specialty	20%, not to exceed $250	30%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	$150	Covered under the HMO tier	Covered under the HMO tier
CT/PET/MRI (per procedure)	No charge	$35	40% after deductible
Lab/X-ray (per encounter)	No charge	$35	40% after deductible
Durable medical equipment	30%	30% after deductible	50% after deductible
Fertility services	$20	20%	40%
Prenatal care and well-baby visits	No charge	No charge	40%
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	20% after deductible	40% after deductible

1. The HMO Tier of the Point-of-Service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) while the Participating Provider and Non-Participating Provider Tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – Telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 13890/13891		
Tier	HMO Tier	Participating Provider Tier	Nonparticipating Provider Tier
Plan deductible (individual/family)	$0/$0	$1,000/$2,000	$2,000/$4,000
Out-of-pocket maximum (individual/family)	$2,000/$4,000	$3,500/$7,000	$7,000/$14,000
Telehealth[2]	No charge	$50	40% after deductible
Preventive care	No charge	No charge	40%
Primary and specialty care visit	$25	$50	40% after deductible
Hospital inpatient (per admission)	$250	$250 + 20% after deductible	$500 + 40% after deductible
Outpatient surgery (per procedure)	$100	20% after deductible	40% after deductible
Emergency care	$150	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$10	$20 preferred, $50 nonpreferred	Not covered
Brand	$30	$40 preferred, $50 nonpreferred	Not covered
Specialty	20%, not to exceed $250	30%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	$150	Covered under the HMO tier	Covered under the HMO tier
CT/PET/MRI (per procedure)	$10	$50	40% after deductible
Lab/X-ray (per encounter)	$10	$50	40% after deductible
Durable medical equipment	30%	30% after deductible	50% after deductible
Fertility services	$25	20%	40%
Prenatal care and well-baby visits	No charge	No charge	40%
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	20% after deductible	40% after deductible

1. The HMO Tier of the Point-of-Service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) while the Participating Provider and Non-Participating Provider Tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – Telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	POS[1]		
NCAL/SCAL plan ID	☐ 13894/13895		
Tier	HMO Tier	Participating Provider Tier	Nonparticipating Provider Tier
Plan deductible (individual/family)	$0/$0	$1,500/$3,000	$3,000/$6,000
Out-of-pocket maximum (individual/family)	$2,500/$5,000	$4,500/$9,000	$9,000/$18,000
Telehealth[2]	No charge	20% after deductible	50% after deductible
Preventive care	No charge	No charge	50%
Primary and specialty care visit	$30	20% after deductible	50% after deductible
Hospital inpatient (per admission)	$500	$500 + 20% after deductible	$1,000 + 50% after deductible
Outpatient surgery (per procedure)	$250	20% after deductible	50% after deductible
Emergency care	$150	Covered under the HMO tier	Covered under the HMO tier
Prescription drugs			
Generic	$10	$20 preferred, $50 nonpreferred	Not covered
Brand	$30	$40 preferred, $50 nonpreferred	Not covered
Specialty	20%, not to exceed $250	30%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	$150	Covered under the HMO tier	Covered under the HMO tier
CT/PET/MRI (per procedure)	$100	20% after deductible	50% after deductible
Lab/X-ray (per encounter)	$10	20% after deductible	50% after deductible
Durable medical equipment	30%	30% after deductible	50% after deductible
Fertility services	$30	20%	50%
Prenatal care and well-baby visits	No charge	No charge	50%
Optical hardware	Not covered	Not covered	Not covered
Prosthetics and orthotics	No charge	20% after deductible	50% after deductible

1. The HMO Tier of the Point-of-Service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) while the Participating Provider and Non-Participating Provider Tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.
2. Telehealth – Telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	PPO[1]			
NCAL/SCAL plan ID	☐ 13898/13899		☐ 13902/13903	
Tier	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
Plan deductible (individual/family)	$500/$1,000	$1,500/$3,000	$750/$1,500	$1,750/$3,500
Out-of-pocket maximum (individual/family)	$3,500/$7,000	$7,000/$14,000	$5,000/$10,000	$10,000/$20,000
Telehealth[2]	$20	40% after deductible	$30	40% after deductible
Preventive care	$0	40%	$0	40%
Primary and specialty care visit	$20	40% after deductible	$30	40% after deductible
Hospital inpatient (per admission)	$250, then 20% after deductible	$500, then 40% after deductible	$250, then 20% after deductible	$500, then 40% after deductible
Outpatient surgery (per procedure)	$100, then 20% after deductible	$150, then 40% after deductible	$100, then 20% after deductible	$150, then 40% after deductible
Emergency care	$150 copay per visit, then 20% after deductible	Covered under the participating provider tier	$150 copay per visit, then 20% after deductible	Covered under the participating provider tier
Prescription drugs				
Generic	$15 for up to a 30-day supply	Not covered	$15 for up to a 30-day supply	Not covered
Brand	$40 for up to a 30-day supply	Not covered	$40 for up to a 30-day supply	Not covered
Specialty	30%, not to exceed $250	Not covered	30%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	40% after deductible	Covered as preferred provider	40% after deductible	Covered as preferred provider
CT/PET/MRI (per procedure)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Lab/X-ray (per encounter)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable medical equipment	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Fertility services	20%	40%	20%	40%
Prenatal care and well-baby visits	$0	40%	$0	40%
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	20% after deductible	40% after deductible	20% after deductible	40% after deductible

1. The Kaiser Permanente PPO Plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.
2. Telehealth—Telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected:

Complete Suite category	PPO[1]			
NCAL/SCAL plan ID	☐ 13906/13907		☐ 13910/13911	
Tier	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
Plan deductible (individual/family)	$1,000/$2,000	$2,000/$4,000	$1,500/$3,000	$3,000/$6,000
Out-of-pocket maximum (individual/family)	$5,000/$10,000	$10,000/$20,000	$5,000/$10,000	$10,000/$20,000
Telehealth[2]	$35	40% after deductible	$35	40% after deductible
Preventive care	$0	40%	$0	40%
Primary and specialty care visit	$35	40% after deductible	$35	40% after deductible
Hospital inpatient (per admission)	$250, then 20% after deductible	$500, then 40% after deductible	$250, then 20% after deductible	$500, then 40% after deductible
Outpatient surgery (per procedure)	$100, then 20% after deductible	$150, then 40% after deductible	$100, then 20% after deductible	$150, then 40% after deductible
Emergency care	$150 copay per visit, then 20% after deductible	Covered under the participating provider tier	$150 copay per visit, then 20% after deductible	Covered under the participating provider tier
Prescription drugs				
Generic	$15 for up to a 30-day supply	Not covered	$15 for up to a 30-day supply	Not covered
Brand	$40 for up to a 30-day supply	Not covered	$40 for up to a 30-day supply	Not covered
Specialty	30%, not to exceed $250	Not covered	30%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	40% after deductible	Covered as preferred provider	40% after deductible	Covered as preferred provider
CT/PET/MRI (per procedure)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Lab/X-ray (per encounter)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable medical equipment	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Fertility services	20%	40%	20%	40%
Prenatal care and well-baby visits	$0	40%	$0	40%
Optical hardware	Not covered	Not covered	Not covered	Not covered
Prosthetics and orthotics	20% after deductible	40% after deductible	20% after deductible	40% after deductible

1. The Kaiser Permanente PPO Plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.
2. Telehealth –Telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans Plans selected: ☐

Complete Suite category	PPO[1]	
NCAL/SCAL plan ID	☐ 13914/13915	
Tier	Participating Provider	Nonparticipating Provider
Plan deductible (individual/family)	$2,000/$4,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$5,000/$10,000	$10,000/$20,000
Telehealth[2]	$40	50% after deductible
Preventive care	$0	50%
Primary and specialty care visit	$40	50% after deductible
Hospital inpatient (per admission)	$500, then 30% after deductible	$1,000, then 50% after deductible
Outpatient surgery (per procedure)	$100, then 30% after deductible	$150, then 50% after deductible
Emergency care	$150 copay per visit, then 30% after deductible	Covered under the participating provider tier
Prescription drugs		
Generic	$15 for up to a 30-day supply	Not covered
Brand	$40 for up to a 30-day supply	Not covered
Specialty	30%, not to exceed $250	Not covered
Emergency ambulance services (per trip)	50% after deductible	Covered as preferred provider
CT/PET/MRI (per procedure)	30% after deductible	50% after deductible
Lab/X-ray (per encounter)	30% after deductible	50% after deductible
Durable medical equipment	30% after deductible	50% after deductible
Fertility services	30%	50%
Prenatal care and well-baby visits	$0	50%
Optical hardware	Not covered	Not covered
Prosthetics and orthotics	30% after deductible	50% after deductible

1. The Kaiser Permanente PPO Plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.
2. Telehealth –Telehealth services include scheduled phone and video visits when appropriate and available.

Compare plans

Plans selected: ☐

Complete Suite category			
NCAL/SCAL plan ID			
Plan deductible Individual (Self-only)/ Family member/Family			
Out-of-pocket maximum Individual (Self-only)/ Family member/Family			
Telehealth			
Preventive care			
Primary and specialty care visit			
Hospital inpatient (per admission)			
Outpatient surgery (per procedure)			
Emergency care			
Prescription drugs Generic Brand Specialty			
Emergency ambulance services (per trip)			
CT/PET/MRI (per procedure)			
Lab/X-ray (per encounter)			
Durable medical equipment			
Fertility services			
Prenatal care and well-baby visits			
Optical hardware			
Prosthetics and orthotics			

The plan summary highlights the most frequently asked-about benefits and is for illustration purposes only. For a complete description, please refer to the appropriate *Evidence of Coverage* or *Certificate of Insurance* booklet, or contact your broker or Kaiser Permanente account manager.

Information may have changed since publication.

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